EXHIBIT D

#26

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

STATE OF DELAWARE,)
)
v.) IN03060175-77
)
JIMMY LEWIS,) I.D.# 0305016966
)
Defendant.)

O R D E R

AND NOW, TO WIT, this 1st day of December, A.D., 2003, the foregoing Motion having been heard and considered, it is hereby;

ORDERED that Jimmy Lewis, the defendant, be transferred to the Delaware State Hospital for psychiatric evaluation for the purpose of determining competency, and to obtain treatment for his own well-being. As soon as Delaware State Hospital notifies Gander Hill of an available opening, Jimmy Lewis is to be transported and evaluated.

JUDGE

EXHIBIT E

Department of Health and Social Services
Division of Mental Health
Delaware Psychiatric Center

Release Summary

LEWIS, JIMMY 12 25
[illegible]NK M AF D
WARK NJ 07112
MELBA JEAN LEWIS MOTHER AREA 5
05 21

MAY 21, 2004	JUNE 25, 2004	DIRECT DISCHARGE
Date of Admission	Date of Discharge	Disposition

IDENTIFYING DATA: This 37 year old black, divorced male was admitted to Delaware Psychiatric Center for his first admission on a court commitment on May 21, 2004.

CHIEF COMPLAINT: Patient refused to speak upon admission. He was selectively mute.

HISTORY OF PRESENT ILLNESS: Mr. Lewis had been jailed at Gander Hill for several months prior to his admission to the Mitchell Building. He had been evaluated by the prison psychiatrist and found to be, "psychotic and delusional, a danger to self and others, refusing to take medication". He had assaulted a CO and was transferred to the infirmary. Patient reported at the time, "I can't distinguish between right and wrong; I'm hearing voices telling me to hurt myself and I'm seeing shadows". He had been incarcerated on 11/17/03 for Car Jacking 2nd Degree, Theft $1000 or Greater and Resisting Arrest.

On 5/26/03, he was picked up by a male driver who was allegedly out looking for a male companion for the evening. Mr. Lewis allegedly attempted to rob the driver, at which point the driver jumped out of the vehicle in fear and Mr. Lewis allegedly drove off with the car. Mr. Lewis allegedly resisted arrest when caught, and was identified by the driver of the car as the person who had stolen his vehicle.

The examiners at First Correctional Medical, while he was in prison, described Mr. Lewis as, "flirtatious at times, requiring redirection for asking personal questions of mental health personnel". He was confronted with his, "narcissism and attention seeking behaviors". The CO questioned the diagnosis of Schizophrenia which had been given to

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him by the prison doctor. Mr. Lewis refused all medications, requesting only Xanax and Valium. He also asked for art materials and pornography, stating, "that would be very helpful". The CO's described him as, "with broad mood and good eye contact with no suicidal or homicidal ideation and no alteration in perception". He was, however, argumentative and loud. He was observed wearing paper horns, saying that the horns made him feel more comfortable. "It helps me deal with what I'm going through. It's like a mask; if I deal with these things within me, I'll be a better person. I'm being unjustly accused." During his time in prison, he was calm and controlled and spoke of hearing voices but stated, "I don't know whether it's voices or just my thoughts".

PAST PSYCHIATRIC AND FAMILY HISTORY: Mr. Lewis stated that he had been seen at Crisis a few times but was never an inpatient at a psychiatric hospital. He said he went to Crisis for having hallucinations, hopeless feelings and suicidal thoughts.

He had been an outpatient as a child in New Jersey but did not know why.

ALCOHOL AND DRUG HISTORY: Mr. Lewis reported that he began drinking alcohol in his teens with his last use just prior to incarceration. He had history of blackouts, but did not elaborate. He denied heavy use. He also admitted to smoking marijuana 16 years previously but denied all other illicit drug use. It was considered probable that he was minimizing his addiction issues.

MENTAL STATUS AT TIME OF ADMISSION: The mental status was obtained four days after admission as Mr. Lewis refused to answer any questions upon admission and just sat staring at the floor. Four days after admission, his mood was stated as sensitive and easily irritated. His affect was constricted. Thought content revealed negative thoughts about himself. He stated that he felt hopeless and helpless to make himself feel any better. He said he was having both auditory and visual hallucinations but only at night when he was upset. He said that he was having current suicidal thoughts. "I was thinking about it, but I didn't really want to do it." He was not having any current violent thoughts. "I was just upset with the guy that attacked me and the CO's blamed me." He denied obsessions, compulsions, paranoid, delusions, special powers, hyperreligiosity and grandiosity. "I'm not on the defensive unless there's a reason." Thought process was normal and there was no evidence of loosening of associations, flight of ideas or tangentiality. Sensorium was alert and he was oriented in three spheres. His immediate memory was intact as he remembered 3/3 objects immediately and 2/3 objects after five minutes. He was able to spell the word "world" backwards but only got the current president. He assessed the similarities between an apple and an orange, as "you eat

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them". He was unable to give an answer to the glass house proverb. Insight and judgment were considered average to poor and his fund of knowledge poor. Intellectual functioning was considered average.

MEDICAL HISTORY AND PHYSICAL EXAMINATION: The patient complained of having irritable bowel syndrome and hypertension.

LABORATORY DATA AND OTHER DIAGNOSTIC EXAMS: Mr. Lewis complained of some urinary frequency during the admission and a urology consult was written. However, he was discharged before being evaluated. He was treated with Bactrim during the admission with resolution of the symptoms. However, as he had complained of these urinary tract symptoms frequently in the past, he was to undergo a urology consult which did not happen, as stated above. Mr. Lewis was treated for hypertension throughout the admission with good results.

Urinalysis revealed a l+ protein and l+ bilirubin. However, the urine C&S revealed no growth. The medical doctor wrote no evidence of the urinary tract infection. The CBC and differential and the comprehensive metabolic panel were completely unremarkable. The hepatic function panel and the thyroid function studies with TSH were all normal. Vitamin Bl2 and folate levels were normal and the RPR was nonreactive.

PROVISIONAL CLINICAL DIAGNOSIS: Axis I: Alcohol Abuse. Rule out Dependence. Rule out Depressive Disorder. Rule out Malingering. Axis II: Deferred. Axis III: Hypertension. Axis IV: Severity of Psychosocial Stressors: Legal. Axis V: Global Assessment of Functioning: Current GAF – 20. Highest Level Last Year – Unknown.

SUMMARY OF CLINICAL COURSE: Mr. Lewis was verbally unresponsive, selective mute and categorically refused to answer any questions on the day of admission. He also refused the initial physical examination. Later the same day, he was observed interacting in a normal manner on the unit. Several days later, the initial examinations were completed without problem. He eventually explained that he had not felt like speaking on the first day, and therefore simply did not.

Mr. Lewis' hospital course was complicated by his aggressive, assaultive behavior. He was overheard making physical threats and observed taunting and laughing at peers, apparently taking pleasure in embarrassing them. He was sexually inappropriate, seductive and flirtatious with certain female staff members. He complained of hearing

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voices sporadically but displayed no evidence of preoccupation with internal stimuli when he believed he was not being observed.

The team psychologist described Mr. Lewis in the following manner in his anger management group: arrogant, disruptive and instigating. While the other older patients tried to have a calming influence, Mr. Lewis displayed no sense of boundaries or respect for authority. The psychologist added that there was nothing odd or bizarre about his behavior that would suggest a psychotic disorder. Other therapists noted that he was disruptive in the group setting, talking out of turn and making obscene comments while watching educational videos. When evaluated by the team, he made it clear that he would rather be at DPC than in jail in order to, "get some help". When asked what help he needed or what we could do for him, he answered he didn't know.

One staff member stated that she found Mr. Lewis to be engaging, intelligent and articulate, but noted his sense of entitlement and his demands that things be done his way. Mr. Lewis stated that he needed to do "outlandish things" to get attention, such as wearing paper horns and wearing his cat's eye lenses. It was explained to him that he would not be allowed to wear his paper horns at any time while at DPC, after he had placed them on his head at one point. He understood, and did not attempt to wear them again. He was noted to attempt to intimidate one female therapist by chasing her in the hallway and stating, "I just want to get my point across that whatever you said about me in team meeting was wrong and derogatory".

On 6/7/04, a special meeting with Mr. Lewis was called to address his grossly inappropriate behavior on the unit the night before. He was angered by not receiving a certain salad at dinner to which he believed he was entitled, and assaulted a peer and a staff member, escalating to the point where he was difficult to redirect. In summary, he was noted to be disruptive in the group setting, to taunt his peers, to intimidate and flirt with therapists and to make obscene comments. There were reports to the contrary by other staff members who reported that Mr. Lewis was cooperative and helpful in the milieu, tending to get loud and demanding at times when he felt his needs were not being met in a timely fashion.

Initially, Mr. Lewis was prescribed no psychotropic medication, as there was no evidence of a mood disorder and no evidence of psychosis. However, Seroquel was begun after it became evident that Mr. Lewis had difficulty managing his anger and controlling his impulses.

Cont...

DISCHARGE SUMMARY
LEWIS, JIMMY
HOSPITAL #46443

FINAL CLINICAL DIAGNOSIS:
AXIS I: MALINGERING. CODE NO. V65.2
ALCOHOL ABUSE. CODE NO. 305.00
HISTORY OF CONDUCT DISORDER.
AXIS II: ANTISOCIAL PERSONALITY DISORDER. CODE NO. 301.7
AXIS III: HYPERTENSION. CODE NO. 401.9
AXIS IV: SEVERITY OF PSYCHOSOCIAL STRESSORS: INCARCERATION.
AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING: CURRENT GAF – 50
WITH SEVERE IMPAIRMENT IN SOCIAL AND OCCUPATIONAL FUNCTIONING.
HIGHEST LEVEL LAST YEAR – UNKNOWN.

CONDITION ON RELEASE: Mr. Lewis displayed no evidence of psychosis, depression or mania. He was still having difficulty with limit setting and boundaries, especially with respect to the rights of others. It was felt that he had not benefited from a psychiatric admission and had not been engageable in therapies. He was having no suicidal and no homicidal ideation and no auditory or visual hallucinations. He admitted during the admission that the "voices" he had been hearing were his thoughts. Mr. Lewis was considered highly manipulative and he would stop at nothing to obtain his demands.

MEDICATION ON RELEASE: Seroquel 50 mgs q l2 hours for anger management and impulse control. Tenormin 25 mgs q a.m. for hypertension. Mr. Lewis was on a lactose intolerance diet and there were no special restrictions on his physical activity.

PROGNOSIS: Guarded to poor as Mr. Lewis was considered threatening and dangerous to others.

RELEASE NOTE AND AFTERCARE PLAN: Mr. Lewis was returned to the care of Department of Corrections with Gerry Greg as a contact person; 995-8614. Mr. Lewis needs daytime socialization activities. Anticipated problems are that he may not be compliant with clinic appointments, may encounter legal difficulties, may encounter family problems and may return to using alcohol or drugs.

Sylvia Foster, M.D.
Staff Psychiatrist

Dict. 07/26/04
Typed 07/29/04
SF/gaf

EXHIBIT F

DELAWARE PSYCHIATRIC CENTER
INCIDENT REPORT

LEWIS, JIMM. 12/25/ K M AF U NJ 07112 MELBA JEAN LEWIS MOTH AREA 5 05/21/2004

Please utilize special forms for staff injuries, unauthorized absence, medication errors, ADR's, PM46
(**indicates items requiring additional information/supplemental forms- Carvel ONL

Name: ______ Date of Incident: 6/21/04 Time of Incident: 8:10 AM (PM)

STATUS
☒ Patient ☐ Employee ☐ Visitor ☐ N/A

UNIT
☐ Carvel-UL ☐ Kent-1 ☐ Sussex-1
☐ Carvel-LL ☐ Kent-2 ☐ Sussex-2
☒ Mitchell ☐ Kent-3 ☐ Sussex-3

LOCATION
☐ Bathroom ☐ Bedroom ☒ Hallway ☐ Canteen
☐ Dayroom ☐ Cafeteria ☐ TX Mall ☐ Court yard
☐ Grounds ☐ Gym ☐ Office ☐ Admissions
☐ Stairs ☐ Off Grounds ☐ Clinic ☐ Workshop
☐ Rec Area ☐ Nsg Station ☐ Pool ☐ Other: ______

TYPE OF INCIDENT
☒ Patient-Patient Aggression ☐ Injury Unknown Origin** ☐ Dietary Related
☐ Patient-Staff Aggression ☐ Equipment Related ☐ Unsafe Practice
☐ Patient-Visitor Aggression ☐ Accidental Injury ☐ Unsafe Condition
☐ Patient-Object Aggression ☐ Slip/Fall ☐ Property Damage/Loss
☐ Patient-Self Aggression ☐ Ingestion/Inhalation ☐ Fire
☐ Suicide Attempt ☐ Choking/Aspiration ☐ Contraband
☐ Death ☐ Sexual Assault/Encounter ☐ Other: ______

RECEIVED
JUL 01 2004
PLANNING DEPARTMENT

PRECAUTIONS (Refers to Precautionary level at the time of the incident - NOT a result of the incident)
☐ Routine ☐ Q15
☐ 1:1 ☐ Seclusion
☐ Restraint ☐ Locked Pod
☐ Code (Specify): ______
☐ Other: ______

DESCRIPTION OF INCIDENT (Include immediate actions taken. Utilize the reverse if more space is necessary)
"I didn't see nothing" - Patients were talking about a cassette tape and began to argue. MR. stopped arguing and said forget it. MR. turned and attempted to walk towards the attendants station that when MR. LEWIS came from his room behind ME and punched him in the right side of (cont. on back)

Witnesses Present: Mike Erickson - James Daniels

Reporter's Signature: [signature] Date: 6/21/04 Time: 8:15 AM/PM

NOTIFICATIONS To be initialed by Nurse in Charge or (non-nursing) Supervisor (if notified)
✓ Physician ✓ Nursing Supervisor ✓ Security ___ Safety Officer
___ Hospital Director/AOC ✓ Unit Director ___ Social Services ___ Other: ______

PHYSICIAN'S REPORT (If medical care was necessary, please specify findings and treatment)
Pt hit another pt on his lower jaw on both sides on exam
Mr Lewis has no injuries

SEVERITY OF INJURY (Completed by MD following examination) ☒ No Apparent Injury/Potential Injury
☐ Minor (Bruises, sprains, welts, etc. requiring first aid or less) ☐ Major** (Fractures, lacerations requiring sutures, internal injury, etc. requiring more than first aid)

Physician's Signature: B. BRIKA MD Date: 6/21/04 Time: 9:10 AM / (PM)

___ DLTCRP** (Carvel Patients) Date DLTCRP Notified: __/__/__ Via: ☐ FAX ☐ Phone

FAX COPY TO RISK MGR. **IMMEDIATELY** (4256) TIME FAXED TO RISK MGR: ______ AM/PM

Family/Guardian Notified? ☐ YES ☐ NO Date: ______ Time: ____ AM / PM Relationship: ______ By Whom: ______

Nurse In Charge/Supervisor's Signature: Helen Harlow RN Date: 6/21/04 Time: 11:45 AM (PM)

SUPERVISOR'S REVIEW (Findings, actions, recommendations)
Pt Refered to tx team for Eval in Am

Supervisor's Signature: [signature] Date: 6/21/04 Time: 11:45 AM (PM)

UNIT DIRECTOR/TREATMENT TEAM REVIEW (Findings, actions, recommendations)
[illegible handwriting]

Unit Director's Signature: [signature] 000176 Date: 6/22/04 Time: ___

FORWARD ORIGINAL REPORT TO CLINICAL RISK MANAGER (DPPI) WITHIN 2 WORKING DA

A-40

DELAWARE PS[...]HIATRIC CENTER
INCIDENT REPORT

Please utilize special forms for staff injuries, unauthorized absence, medication errors, ADR's, PM46
*(**indicates items requiring additional information/supplemental forms- Carvel ONLY)*

LEWIS, JIMMY 12/25, JNK M AF U EWARK NJ 07112 5028 05/21/2004

Name: Lewis Jimmy

Date of Incident: ____ Time of Incident: ____ AM / PM

STATUS
☐ Patient ☐ Employee ☐ Visitor ☐ N/A

UNIT
☐ Carvel-UL ☐ Kent-1 ☐ Sussex-1
☐ Carvel-LL ☐ Kent-2 ☐ Sussex-2
☑ Mitchell ☐ Kent-3 ☐ Sussex-3

LOCATION
☐ Bathroom ☐ Bedroom ☐ Hallway ☐ Canteen
☐ Dayroom ☐ Cafeteria ☐ TX Mall ☐ Court yard
☐ Grounds ☐ Gym ☐ Office ☐ Admissions
☐ Stairs ☐ Off Grounds ☐ Clinic ☐ Workshop
☐ Rec Area ☐ Nsg Station ☐ Pool ☐ Other: ____

TYPE OF INCIDENT
☐ Patient-Patient Aggression ☐ Injury Unknown Origin** ☐ Dietary Related
☑ Patient-Staff Aggression ☐ Equipment Related ☐ Unsafe Practice
☐ Patient-Visitor Aggression ☐ Accidental Injury ☐ Unsafe Condition
☐ Patient-Object Aggression ☐ Slip/Fall ☐ Property Damage/Loss
☐ Patient-Self Aggression ☐ Ingestion/Inhalation ☐ Fire
☐ Suicide Attempt ☐ Choking/Aspiration ☐ Contraband
☐ Death ☐ Sexual Assault/Encounter ☐ Other: ____

RECEIVED
JUL 01 2004
PLANNING DEPAR[...]

PRECAUTIONS (Refers to Precautionary level at the time of the incident - NOT a result of the incident)
☐ Routine ☐ Q15
☐ 1:1 ☐ Seclusion
☐ Restraint ☐ Locked Pod
☐ Code (Specify): ____
☐ Other: ____

DESCRIPTION OF INCIDENT (Include immediate actions taken - Utilize the reverse if more space is necessary)
Pt was placed in 4 pt Restraints while The Nurse was Checking The Restraints The Pt Struck The Nurse In The Face

Witnesses Present: Brian Johnson ATF Hellen Hardland RN

Reporter's Signature: ____ Date: ____ Time: ____ AM/PM

NOTIFICATIONS To be initialed by Nurse in Charge or (non-nursing) Supervisor (if notified)
____ Physician ____ Nursing Supervisor ____ Security ____ Safety Officer
____ Hospital Director/AOC ____ Unit Director ____ Social Services ____ Other: ____

PHYSICIAN'S REPORT (If medical care was necessary, please specify findings and treatment)
Mr. Lewis punched on the face the nurse while he was checking the restraints. No injuries sustained by pt.

SEVERITY OF INJURY (Completed by MD following examination) ☐ No Apparent Injury/Potential Injury
☐ Minor (Bruises, sprains, welts, etc. requiring first aid or less) ☐ Major** (Fractures, lacerations requiring sutures, internal injury, etc. requiring more than first aid)

Physician's Signature: B ERIKA MD Date: 6/21/04 Time: 11:30 AM / PM (circled)

____ DLTCRP** (Carvel Patients) Date DLTCRP Notified: __/__/__ Via: ☐ FAX ☐ Phone

FAX COPY TO RISK MGR. IMMEDIATELY (4256) **TIME FAXED TO RISK MGR:** ____ **AM/PM**

Family/Guardian Notified? ☐ YES ☐ NO Date: ____ Time: ____ AM / PM Relationship: ____ By Whom: ____

Nurse in Charge/Supervisor's Signature: ____ Date: ____ Time: ____ AM / PM

SUPERVISOR'S REVIEW (Findings, actions, recommendations)
Pt Referred to TX Team for Evaluation of Conduct

Supervisor's Signature: [signature] Date: 6/21/04 Time: ____ AM / PM

UNIT DIRECTOR/TREATMENT TEAM REVIEW (Findings, actions, recommendations)
incident noted — [illegible] [illegible] [illegible] [illegible] [illegible] Continued [illegible] of

Unit Director's Signature: [signature] Date: 6/22/04 Time: ____

FORWARD ORIGINAL REPORT TO CLINICAL RISK MANAGER (DPPI) WITHIN 2 WORKING DAYS

A-41

000177

35-96-017-00-03-01

DELAWARE PSYCHIATRIC CENTER
INCIDENT REPORT

Please utilize special forms for staff injuries, unauthorized absence, medication errors, ADR's, PM46
*(**indicates items requiring additional information/supplemental forms- Carvel ONLY)*

12/25.
UNK H AF U
K NJ 07112
MELBA JEAN LEWIS MOTH AREA 5
05/21/2004

Name: Lewis J

Date of Incident: 6/24/04 **Time of Incident:** 12:30 AM / PM

STATUS
☒ Patient ☐ Employee ☐ Visitor ☐ N/A

UNIT
☐ Carvel-UL ☐ Kent-1 ☐ Sussex-1
☐ Carvel-LL ☐ Kent-2 ☐ Sussex-2
☒ Mitchell ☐ Kent-3 ☐ Sussex-3

LOCATION
☐ Bathroom ☐ Bedroom ☐ Hallway ☐ Canteen
☐ Dayroom ☐ Cafeteria ☐ TX Mall ☐ Court yard
☐ Grounds ☐ Gym ☐ Office ☐ Admissions
☐ Stairs ☐ Off Grounds ☐ Clinic ☐ Workshop
☐ Rec Area ☐ Nsg Station ☐ Pool ☐ Other: ______

TYPE OF INCIDENT
☒ Patient-Patient Aggression ☐ Injury Unknown Origin** ☐ Dietary Related
☐ Patient-Staff Aggression ☐ Equipment Related ☐ Unsafe Practice
☐ Patient-Visitor Aggression ☐ Accidental Injury ☐ Unsafe Condition
☐ Patient-Object Aggression ☐ Slip/Fall ☐ Property Damage/Loss
☐ Patient-Self Aggression ☐ Ingestion/Inhalation ☐ Fire
☐ Suicide Attempt ☐ Choking/Aspiration ☐ Contraband
☐ Death ☐ Sexual Assault/Encounter ☐ Other: ______

RECEIVED
JUL 0 1 2004
PLANNING DEPARTMENT

PRECAUTIONS (Refers to Precautionary level at the time of the incident - NOT a result of the incident)
☐ Routine ☐ Q15
☐ 1:1 ☐ Seclusion
☐ Restraint ☐ Locked Pod
☐ Code (Specify): ______
☐ Other: ______

DESCRIPTION OF INCIDENT (include immediate actions taken - Utilize the reverse if more space is necessary)

- Pt. threw his lunch tray on floor x2 ō provocation. Pt. threatening staff, cursing towards staff. not following verbal direction given staff.

Witnesses Present: ______

Reporter's Signature: [signature] **Date:** 6/24/04 **Time:** 12 30 pm AM/PM

NOTIFICATIONS To be initialed by Nurse in Charge or (non-nursing) Supervisor (if notified)
✓ Physician ✓ Nursing Supervisor ✓ Security ___ Safety Officer
___ Hospital Director/AOC ✓ Unit Director ___ Social Services ___ Other: ______

PHYSICIAN'S REPORT (if medical care was necessary, please specify findings and treatment)

Pt. on 4 point restrains because of aggressive behavior. He did not hurt anybody. neither himself

SEVERITY OF INJURY (Completed by MD following examination) ☒ No Apparent Injury/Potential Injury
☐ Minor (Bruises, sprains, welts, etc. requiring first aid or less) ☐ Major** (Fractures, lacerations requiring sutures, internal injury, etc. requiring more than first aid)

Physician's Signature: COCCHELLA M.D **Date:** 6/24/04 **Time:** 2 35 AM / PM

___ DLTCRP** (Carvel Patients) Date DLTCRP Notified: __/__/__ Via: ☐ FAX ☐ Phone

FAX COPY TO RISK MGR. IMMEDIATELY (4256) **TIME FAXED TO RISK MGR:** ______ **AM/PM**

Family/Guardian Notified? ☐ YES ☒ NO Date: — Time: — AM / PM Relationship: — By Whom: —

Nurse in Charge/Supervisor's Signature: [signature] **Date:** 6/24/04 **Time:** 3pm AM / PM

SUPERVISOR'S REVIEW (Findings, actions, recommendations)

Pt in seclusion 4 point PRN given.

Supervisor's Signature: [signature] **Date:** 6/24/04 **Time:** 3pm AM / PM

UNIT DIRECTOR/TREATMENT TEAM REVIEW (Findings, actions, recommendations)

threatening escalated to unit — 4 pt restraint / aggression Back placed in 1:1 2 to 0 aggression

Unit Director's Signature: [signature] **Date:** 6/25 **Time:** ___

FORWARD ORIGINAL REPORT TO CLINICAL RISK MANAGER (DPPI) WITHIN 2 WORKING DA

D001178

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